

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/11/2016
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ANTHONY HEALTH - MICHIGAN CIT		STREET ADDRESS, CITY, STATE, ZIP CODE 301 W HOMER ST MICHIGAN CITY, IN 46360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State Complaint.</p> <p>Complaint number: IN00180440</p> <p>Unsubstantiated: lack of sufficient evidence.</p> <p>Date of survey: 5/11/2016</p> <p>Facility #: 005015</p> <p>Franciscan St. Anthony Health is in compliance with 410 IAC 15-1.6.2, Emergency services, Hospital Licensure Rules.</p> <p>QA: 6/9/16 jlh</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE